



WyIR Remove User Form

Immunization Registry Manager or Immunization Program Authorized Personnel:

Please be advised the authorized user listed below has terminated employment with our organization. Notice of this termination of employment is being given with twenty-four (24) hours of the employee's last day of employment.

(FAX a copy of the Remove User form to the Immunization Program. Retain copy in employee personnel file).

Please Complete the following:

1. Name of Health Care Organization: _____
2. Pin # (If Applicable): _____
3. Individual who need Wyoming Immunization Registry Access Removed:

First Name	Last Name	Position/Title	Date of Removal

Signature of Representative

Date